HSTA-R EC-2H Hawai'i Employer-Union Health Benefits Trust Fund

PLEASE SUBMIT THIS FORM EC-2H TO THE EUTF

DEC 2010

## **HSTA:** Enrollment Form For HSTA Retirees

The EUTF created new health and life insurance benefit plans for HSTA VEBA retirees in response to the December 7, 2010 oral ruling by Judge Sakamoto. The new plans offer HSTA VEBA members the same standard of coverage in benefits that they enjoyed under their HSTA VEBA plans. All HSTA VEBA retirees will be transitioned to the newly created EUTF plans that offer the same standard of coverage in benefits on January 1, 2011.

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SECTION 1: RETIREE DATA			Please complete all applicable fields below. Social Security numbers are required to process new retiree and dependent enrollments							
Name (Last, First, N	Aiddle)		☐ Open Enrollment		Mid- Year Q  Event Date:	ualifying Event				
Home Phone (	)		Retiree's Social Security (SSN) or EUTF ID Numb		Gender ☐ Male Birth Date: (MM	e 🔲 Female	)			
Mobile Phone (	)									
Street	( Check this box if your address h		Marital Status ☐ Marrie Marriage Date: (MM/DD/YY		Domestic Partne IRS Qualified DP Date: (MM/DE	ed 🔲 Not Qu				
City	State	Zip Code	/			_//				
Mailing Address (if d			If you are including you or domestic partner in benefit plans, please of Section 4	your health	Special Note: If Partner is a Sta Retiree and is n plans, please pr SSN: EUTF ID:	te or County El ot being enroll ovide his/her	mployee or ed in your or			
	SELECTION led within 30 days of qual your event is listed below this section.			r a selection		age and Cor	ntribution			
Qualifying E for this Sect		Available Option	Available Options for this Section							
	, Marriage, New Domestic	Coverage starts day of the event & premium contributions start first day of the pay period* in which the effective date of coverage occurs (if no selection is made, this option will be used)								
Partnership, Pla	acement for Adoption,	☐ Coverage & pre	mium contributions start fi	irst day of the	first pay period*	following ever	nt			
Guardianship, New Eligible Student		☐ Coverage & premium contributions start first day of the second pay period* following event *(1 <sup>st</sup> or 16 <sup>th</sup> of month)								
SECTION	3: PLAN SELEC	CTION	Make your selection plans below. Selection Choose only one be	t Self, 2-Par	ty, Family or Ca	e appropriate ancel/Waive	e benefit coverage.			
Medical Plan					e only one box	-	n section			
Туре	Carrier Selection			Cancel/Wa	ive Self	2-Party	Family			
	HMSA 90/10 PPO Med Chiro Plan Program	lical and Drug, VS	SP Vision &							
Hawaii Kaiser Foundation Medical and Chiro Plan Program			Orug, VSP Vision &							
Other Plans				Cancel/Wa	aive Self	2-Party	Family			
	Hawai'i Dental Service	(HDS) Dental Pla	าท							
Life	Standard Insurance Co	· · · · · · · · · · · · · · · · · · ·								
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		N 4: DEPENDENT INFORMATION							0	
	-	dependents you wish to cover and check the plan seled, DPCH= Domestic Partner's Child, GC=Guardianship			•			-		or your
Opouc		Dependent(s):	Birth Date	Social Security Number	· ·	Gender			2.04.	
Add	Delete	Last Name (if different), First Name, Middle Initial	(MMDDYYYY)	or EUTFID Number	*Relationship	M/F	Medical	Drug	Dental	Vision
			/ /							
			/ /							
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	Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii'i Revised Statutes.  Dependent Cortification and Student Cortification - See Sections 4.6 and 4.7 of "Instructions for Completing Form EC-2"for more information.									
Dependent Certification and Student Certification—See Sections 4.6 and 4.7 of "Instructions for Completing Form EC-2"for more information.  I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans (initials)										
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	I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. (initials)									5)
Domestic Partner Certification – See Sections 4.8 and 4.9 of "Instructions for Completing Form EC-2" for specific instructions.  I have attached all documentation as required in the Domestic Partner Enrollment Instructions.  (initials)										s)
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		N 5: MEDICARE	icara Part P ac a	andition of receiving	ag contributio	no ond n	artiainat	ina in th	o ELITE	honofit
Chapter 87A-23(4) requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.										
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Medicare Claim #: (ID number listed on the blue and red Medicare Card)										
	_	Medicare Part D								
		ur dependent(S) are enrolled in a non-EUTF Nater the name(s) of those enrolled in a non-EU			plan, pleas	e read S	Section	5 on th	ne instr	uction
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-	Name(	s):		пт в ріап.						
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Please submit your signed and completed form via mail to:

EUTF P.O. Box 2121 Honolulu HI 96805-2121 <u>Customer Service:</u>
Oahu (808) 586-7390
Toll Free 1 (800) 295-0089

Or hand deliver at: EUTF, 201 Merchant St., Suite 1520, Honolulu HI 96813

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